**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthnewengland.org or by calling 800.310.2835.

| Important Questions | Answers | Why this Matters |
|---|---|---|
| **What is the overall deductible?** | $500 person / $1,000 family – Doesn't apply to in-plan preventive care. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket maximum on my expenses?** | Yes. In-plan: $5,000 person / $10,000 family. Out-of-plan: $6,000 person / $12,000 family. | The out-of-pocket maximum is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket maximum?** | Premiums; healthcare this plan does not cover; balance billed charges; your cost sharing for benefits that are not Essential Health Benefits under national health care reform | Even though you pay these expenses, they don't count toward the out-of-pocket maximum. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See www.healthnewengland.org or call 800.310.2835 for a list of participating providers. | If you use an in-plan doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-plan doctor or hospital may use an out-of-plan provider for some services. Plans use the term in-plan, in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| **Do I need a referral to see a specialist?** | No. | You can see the specialist you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services. |

- **Copays** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-plan **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-plan hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-plan **providers** by charging you lower **deductibles**, **copays** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use an In-plan Provider | Your cost if you use an Out-of-plan Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20/visit | 20% after deductible | Deductible may apply to some In-Plan office services. |
| | Specialist visit | $20/visit | 20% after deductible | Deductible may apply to some In-Plan office services. |
| | Other practitioner office visit | $10 for chiropractor | $10 copay, then 20% for chiropractor | Limited to 12 visits per year. |
| | Preventive care / screening / immunization | No charge | 20% after deductible | Routine eye exams limited to 1 per year. Routine gynecological exams limited to 1 per year. Routine mammograms limited to 1 per year. Screening colonoscopy limited to 1 every 5 years. Nutritional counseling limited to 4 visits per year. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge (x-ray subject to deductible) | 20% after deductible | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | $75 after deductible; maximum 3 copays per year | 20% after deductible | Requires prior approval. |
| **If you need drugs to treat your illness or condition.** | Generic drugs | $10 retail, $10 mail order / prescription | $10 copayment, then 20% retail / prescription | Covers up to a 30 day supply (retail); 90 day supply (mail order). Some drugs require prior approval by Health New England (HNE). |

| Common Medical Event | Services You May Need | Your cost if you use an In-plan Provider | Your cost if you use an Out-of-plan Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **More information about prescription drug coverage is available at healthnewengland.org.** | Formulary brand drugs | $25 retail, $25 mail order / prescription | $25 copayment, then 20% retail / prescription | Covers up to a 30 day supply (retail); 90 day supply (mail order). Some drugs require prior approval by HNE. |
| | Non-Formulary brand drugs | $45 retail, $45 mail order / prescription | $45 copayment, then 20% retail / prescription | Covers up to a 30 day supply (retail); 90 day supply (mail order). Some drugs require prior approval by HNE. |
| | Specialty drugs | Copay depends on drug category. | Not covered | Some drugs require prior approval. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) and Physician/surgeon fees | No charge after deductible | 20% after deductible | Some services require prior approval; office visit copay may apply if done in an In-Plan doctor's office. |
| **If you need immediate medical attention** | Emergency room services | $150/visit | $150/visit | ----------none---------- |
| | Emergency medical transportation | $100 /Member /day after deductible | $100 /Member /day after deductible | ----------none---------- |
| | Urgent care | $20/visit | 20% after deductible | Deductible may apply to some In-Plan office services. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) and Physician/surgeon fees | No charge after deductible | 20% after deductible | Elective admissions to Out-of-Plan facilities require prior approval. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $20/visit | 20% after deductible | ----------none---------- |
| | Mental/Behavioral health inpatient services | No charge after deductible | 20% after deductible | ----------none---------- |
| | Substance use disorder outpatient services | $20/visit | 20% after deductible | ----------none---------- |
| | Substance use disorder inpatient services | No charge after deductible | 20% after deductible | ----------none---------- |
| **If you are pregnant** | Prenatal and postnatal care | No charge | 20% after deductible | Deductible and copays may apply for In-Plan non-routine services. |

| Common Medical Event | Services You May Need | Your cost if you use an In-plan Provider | Your cost if you use an Out-of-plan Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Delivery and all inpatient services | No charge after deductible | 20% after deductible | Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth. |
| **If you need help recovering or have other special health needs** | Home health care | No charge after deductible | 20% after deductible | Requires prior approval. |
| | Rehabilitation services | $20/visit per treatment type after deductible | 20% after deductible | Limited to two months or 25 visits, whichever is greater, per condition per calendar year for physical or occupational therapy. |
| | Habilitation services | No charge | 20% after deductible | Early intervention services covered for children from birth to age 3. |
| | Skilled nursing care | No charge after deductible | 20% after deductible | Limited to 100 days per calendar year; admissions to Out-of-Plan facilities require prior approval. |
| | Durable medical equipment | 20% | 20% after deductible | Some items require prior approval. |
| | Hospice service | No charge | 20% after deductible | Requires prior approval. |
| **If your child needs dental or eye care** | Eye exam | No charge for routine exams | 20% after deductible | Routine exams limited to one per calendar year. |
| | Glasses | Not covered | Not covered | ----------none---------- |
| | Dental check-up | Not covered | Not covered | ----------none---------- |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic Surgery
- Dental care (except for the limited services specified in your plan materials)
- Glasses
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (routine foot care is covered if you have diabetes)
- Weight loss programs

**Other Covered Services** **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery (requires prior approval)
- Chiropractic Care
- Hearing aids – limited to members age 21 and under, $2,000 per hearing aid per ear each 36 months.
- Infertility treatment (requires prior approval)
- Routine eye care

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800.310.2835. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877.267.2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Health New England Member Services at 800.310.2835.
- U.S. Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3272) or dol.gov/ebsa/healthreform.
- Massachusetts Division of Insurance at 617.521.7777.

Additionally, a consumer assistance program can help you file your **appeal**. Contact:

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
800.272.4232

or www.massconsumerassistance.org

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,970
- **Patient pays** $570

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $500 |
| Copays | $70 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$570** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,490
- **Patient pays** $910

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $900 |
| Coinsurance | $10 |
| Limits or exclusions | $0 |
| **Total** | **$910** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copays**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copays**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.